Updated December 16, 2020
DOH 820-113

Washington State K-12 School Testing Guidance

This document is a complementary guidance document to the K-12 Schools – Fall 2020-2021 Guidance by the Washington State Department of Health (DOH) Fall K-12 guidance. This guidance is specific to public or private schools serving kindergarten through 12th grade (K-12). Use this guidance to make determinations on who, how, and when to test/screen students and staff in the K-12 school environment. It is our assumption that you make all decisions in coordination with the local health jurisdictions (LHJ).

This guidance is based on existing science, expert public health opinion, current policies, and stakeholder input. This guidance uses information from the CDC's Interim Considerations for Testing for K-12 School Administrators and Public Health Officials, Washington State's Employer Health & Safety Requirements for School Scenarios, CDC COVID-19 Considerations for Schools guidance, and King County Schools COVID-19 Response Toolkit Guidance For K-12 Schools.

Note: Washington state is conducting a school testing pilot with 12 school districts across the state over the next 3 months, with a focus on equipping schools to become access points for diagnostic testing. This guidance is subject to change per best practices and recommendations from the pilot.

Key Principles for Reducing Potential Exposures and Outbreaks

The main ways of reducing exposure to the coronavirus and other respiratory pathogens involve:

- **Keeping ill persons out of school.** Educate students, families and staff to stay home when sick, and use screening methods.
- **Using cohorts.** Conduct all activities in small groups that remain together over time with minimal mixing of groups.
- **Social distancing.** Minimize close contact (less than six feet) with other people.
- **Hand hygiene.** Frequently wash with soap and water or use alcohol-based hand gel.
- **Protective equipment.** Use face coverings or shields and other barriers between people. For employees, follow all Labor and Industries (L&I) and Employer Health & Safety Requirements for School Scenarios guidance.
- **Prompt, open and transparent notification of potential exposures**. As transmission in congregate settings may occur to others than those identified as close contacts, communication of lower risk exposure allows families and staff to make informed decisions about continued attendance.
- **Environmental cleaning and disinfection.** Prioritize the cleaning of high-touch surfaces.
- **Improve indoor ventilation.** Open windows when possible and optimizing HVAC configurations and settings to optimize air changes per hour.
- **Isolation.** Isolate sick people.
- **Quarantine.** Exclude exposed people.

- **Low risk spaces.** Outdoor spaces are safer than indoor spaces. Consider moving activities outdoors when possible.

Health Screening at Entry

Screen students and staff before or upon arrival to school to reduce risk for transmission of COVID-19. Students and staff with any illness must stay home or return home. Schools have flexibility in how to enact daily health screening, whether by assessment at home by parents/guardians, on the school site screening, a combination of these, or other method. See Fall K-12 guidance for details. Use Appendix A for Symptom Evaluation and Management in School and Childcare. The mitigation measures and school screening guidance above are the framework for any testing strategy in schools. To clarify testing in the school settings we outline the most important roles and responsibilities below.

When making decisions about excluding ill persons and readmitting them, please reference the Symptom Evaluation Flow Chart.

Roles and Responsibilities

Managing COVID-19 within schools to help reduce transmission and keep students, staff and families healthy and safe requires a coordinated team response. Identifying staff to play specific roles within the team is critical to ensuring a coordinated response. The following is a list of suggested roles within the school and district to facilitate a coordinated response to COVID-19 related illness events. An excellent toolkit to use as a resource for detailed position descriptions has been created by Public Health Seattle & King County and can be found in this link: King County Schools COVID-19 Response Toolkit

- District COVID-19 Coordinator
- School COVID-19 Coordinator(s)
- COVID-19 Screening Lead
- COVID-19 Isolation Supervisor
- Infection Control Lead

District COVID-19 Coordinator

Monitoring and managing outbreaks among schools requires the partnership between the Washington State Office of Superintendent of Public Instruction (OSPI), Washington State Department of Health (DOH), local health jurisdictions, school district leaders and school administrators.

1. Serves as liaison to Public Health Local Health Jurisdiction (LHJ).
2. Informs the LHJ about confirmed COVID-19 cases in each school.
3. Maintains and updates School Case & Close Contact List Template. (toolkit resource B) for the district.
4. Distributes protocols, procedures, and resources to the School COVID-19 Coordinator(s).
5. Updates protocols, procedures and school resources as new or revised guidance from CDC and DOH becomes available.

6. Serves as the point-of-contact for questions and information for the community-at-large as well as related stakeholders/school district partners.

School COVID-19 Coordinator(s)

A site-specific COVID-19 supervisor shall be designated by the employer at each school and other work sites to monitor the health of employees and enforce the COVID-19 job site safety plan. The LHJ will notify the designated COVID coordinator at each school of the name of each child, teacher, or staff who is a confirmed case when we know they have been present in school during a potentially contagious period. We will also provide this information for close contacts of confirmed cases, with specific dates that they will need to be excluded from school for quarantine. Additional responsibilities of the coordinator includes:

1. Provides resources and information about COVID-19 and quarantine/isolation to ill staff and families of ill students, such as fact sheets for families and staff (toolkit resource D).
2. Gathers additional information about close contacts for tracking on the School Case & Close Contact List Template.
3. Serves as liaison to District COVID-19 Coordinator. Sends completed School Case & Close Contact List Template to District COVID-19 Coordinator and alert them to COVID-19 positive cases in school.
4. Manages internal and external communications regarding outbreak status of the school. Schools will most likely know about cases (and potential cases) before an LHJ knows about them and must be prepared to make decisions. LHJ's will be available for consultation on all confirmed cases and their close contacts. Schools must be open, prompt, transparent, and thorough in their communications to the school community when infected persons have been present in the schools and potentially exposed others. A formal communications plan and written and verbal communications are recommended.
5. Serves as the point-of-contact to answer questions and provide information for staff/students/families.
6. Notifies close contacts of COVID-19 positive student/staff of the exposure and need to quarantine.
7. Maintains a list of classrooms and other cohorts with dates of when COVID-19 positive student/staff have been present while infectious.
8. Notifies all families and staff in a cohort when a COVID-19 positive student/staff has been present in school during the infectious period.
9. Maintains and disseminates COVID-19 procedures, protocols and information to all staff, students and families, including privacy policies regarding COVID-19 health information and infection status.
10. Assures that there is staff designated and available daily to fulfill COVID-19 Response Team roles within the school.

COVID-19 Screening Lead

1. Gathers information about symptomatic students and staff.
2. Notifies parent/guardian to facilitate student/staff getting home safely.

3. Gathers preliminary information for School Case & Close Contact List Template, including dates of infectious period to identify the dates.
4. Ensures that students/staff use cloth face coverings, maintain social distancing, and adhere to other routine COVID-19 prevention measures.
5. Notifies Infection Control Lead of need to initiate infection control protocols.

COVID-19 Isolation Supervisor

1. Supervises area where students/staff who develop COVID-19 symptoms while at school are kept until they can leave school.
2. Assures that student/staff remain masked and maintain minimum social distance from others while waiting.
3. Assures that student is released to parent/guardian or designee.

Infection Control Lead

1. Prepares COVID-19 cleaning and disinfecting plans and regularly updates plans with new or revised CDC and WA DOH guidance.
2. Facilitates initiation of cleaning and disinfecting protocols of all affected areas.
3. Notifies custodial staff that affected area(s) must be cleaned and disinfected in accordance with CDC COVID-19 cleaning/disinfection protocols.
4. Assures that affected areas are not used until cleaning is complete.
5. Assures that COVID isolation area is disinfected daily.
6. Confirms that custodial staff has completed cleaning and disinfecting all affected areas.
7. Maintains and updates cleaning and disinfecting protocols (toolkit resource M).

Testing Recommendations

Testing to diagnose COVID-19 is part of a comprehensive strategy and should be used in conjunction with promoting behaviors that reduce spread (e.g., mask use, social distancing, hand hygiene); maintaining healthy environments (e.g., cleaning and disinfection, ventilation); maintaining healthy operations (e.g., scheduling, virtual learning, class sizes); and preparing for when someone gets sick as well as screening all students and staff for signs and symptoms of illness.

Types of tests to identify SARS-CoV-2, the virus that causes COVID-19

Table 1 summarizes the main types and characteristics of tests used to diagnose a current SARS-CoV-2 infection, the virus that causes COVID-19. Additional information can be found on CDC's SARS-CoV-2 testing pages. Throughout this document, "testing" refers to viral testing for potential infection. Tests used to show past SARS-CoV-2 infection (i.e., antibody tests) are not included in this document. CDC does not currently recommend using antibody testing as the sole basis for diagnosis of current infection.

We support the use of any Coronavirus 19 diagnostic device that has an Emergency Use Authorization (EUA) and the choice of specific test should be guided in consultation with the LHJ. A list of Covid 19 EUA's are listed here.

Table 1: Types of COVID-19 tests currently available to diagnose infection		
	Viral Tests	
	Molecular Tests	**Antigen Tests**
How is the sample taken?	Nasal or throat swab (most tests); saliva or sputum test (a few tests).	Nasal or throat swab.
What does it test?	Diagnose current SARS-CoV-2 infection by detecting viral genetic material (Nucleic acid amplification tests (NAAT), including real-time reverse-transcriptase Polymerase chain reaction (RT-PCR).	Diagnose current SARS-CoV-2 infection by detecting viral proteins.
How are the results used?	Help public health officials identify and recommend isolation for people with active infection in order to minimize COVID-19 transmission.	Help public health officials identify and recommend isolation for people with active infection in order to minimize COVID-19 transmission.
Who administers test?	Nasal or throat swab can be self-collected in the company of a health professional or can be collected by a health professional. Test must be performed by trained staff in a Clinical Laboratory Improvement Amendments (CLIA)-certified laboratory or point-of-care testing site operating under certificate of waiver.	Test must be administered by trained staff associated with CLIA-certified laboratory or point-of-care site that has a certificate of waiver.
Other information	Considered the gold standard for COVID-19 detection and are typically performed in a specialized laboratory. A few molecular tests have been authorized for and have data supporting use in asymptomatic individuals. Some molecular tests can be performed at or near the point of care.	May be more likely to miss a current infection than molecular tests such as RT-PCR. We are learning more about how best to use antigen tests as more information becomes available. A number of ongoing studies are looking at how well they perform in people without symptoms and how often they need to be repeated to assure infection is identified early. The results of these studies should help refine how best to use them.

		Performed at or near the point of care.
How long does it take to get results?	Usually 1 to 3 days; 15-90 minutes for some point-of-care platforms.	Approximately 15 minutes.

Testing Strategies

Each school district and LHJ have unique considerations and requirements for any testing strategy for COVID-19. We present several models for consideration by each school district and LHJ. These include 1. surveillance testing of a sample of staff and students, 2. testing ill students and staff, 3. screening of students and staff on a regular basis, or 4. testing of contacts during an outbreak. The planning with the school district and LHJ is the critical first step in deciding on a testing strategy for schools.

The available options in Washington State include but are not necessarily limited to the following and are not necessarily mutually exclusive.

1. Surveillance Testing

Option 1
Testing weekly 20% of total school population.
Option 2
Testing weekly 50% of total school population.
Option 3
Test all students weekly.
Option 4
Screen cohorts (randomly or all) with pooled testing.
Option 5
Schools in a community where the LHJ is recommending expanded testing on a voluntary basis including testing of a random sample (20%) of asymptomatic individuals, especially in areas of moderate to high community transmission.

2. Targeted testing for all ill students and staff

Option 1
All ill students and staff are sent off site for diagnostic testing to medical home or testing sites in the community.
Option 2
Ill students and staff that screen positive for symptoms receive testing immediately in a school-based testing site or associated site with non-school health staffing.

3. Testing of targeted asymptomatic students and staff

Option 1
Test all students and staff involved in in-person learning before their first day on campus
Option 2

Test all in-person students-and-staff after return from Thanksgiving, Christmas, and Winter break holidays

Option 3

1. Test students with mask exemptions and/or who require significant, ongoing hands-on close contact.
    a. They are the children that are needing mask exemptions.
    b. The teachers are hands-on with these children and are unable to social distance.

2. Test all teachers/para-pros weekly who work in classrooms with students with mask exemptions and/or who require significant, ongoing hands-on close contact.

3. Consider testing all K-2 teachers weekly for the same reasons as above.

4. Outbreak Testing

Option 1

1. Test all contacts and (where appropriate) extended circles in outbreak settings

Option 2

1. If cohorting is occurring in the school setting and a single person (staff or student) is positive, test the entire cohort

Strategy Summary & Comparison

Strategy	Pros	Cons
Surveillance testing	Provides ongoing data to inform whether and to what degree infections are present in the school population. May be helpful in detecting outbreaks. May be helpful in decision making about in-person presence among vulnerable staff and students.	Depending on surveillance design, results may not be releasable to testing subjects. If refusal correlates with risk of infection, results may be biased downward (and vice versa). Major investment of staff time, space and materials. Role in overall goal of preventing hospitalizations not well documented.
Targeted tested of ill students and staff	May identify the majority of infections of disease control significance. Efficient and more manageable.	Effectiveness in curtailing asymptomatic spread not clear. Asymptomatic transmitters may be missed.
Testing of targeted asymptomatic students and staff	See surveillance testing above.	See surveillance testing above.

Outbreak testing	By identifying asymptomatic infections it may inform about the size of the outbreak and need for closure. May help in stemming spread into the community.	By the time an outbreak is detected, it might be more efficient to just close the school temporarily and refer everyone to existing community-based resources for testing.

When testing might be performed

Schools can play an important role in assisting public health officials in identifying teachers, staff, or students who have COVID-19 symptoms or who had recent close contact (e.g., within 6 feet for a total of 15 cumulative minutes or more within a 24 hour period) with someone with COVID-19. If the school is experiencing an outbreak, the school should immediately notify the LHJ, cooperate with investigation methods, and follow all LHJ direction related to isolation, quarantine and other mitigation measures. This direction may include increased testing and contact tracing, as deemed necessary by the LHJ.

Which schools and persons should be prioritized for school-based testing?

LHJs and school districts can work together to develop a strategy for prioritizing school-based testing in K-12 schools, depending on resources and goals. DOH recognizes that there are limitations in resources at the local level and large or widespread testing strategies may be infeasible. DOH is currently working to identify several pilot projects for school-based testing in Washington to inform future guidance and local decision making in this realm.

There are three levels of decision-making when it comes to selecting school-based testing:

- Which schools?
- Which persons in those schools?
- Which strategies?

Schools that have opened for any in-person classes (including hybrid, which includes combination of in-person and virtual classes) can benefit from developing a testing strategy. CDC's Indicators for Dynamic School Decision-Making can be used to determine which schools may provide the best settings for school-based testing based on infection risk. In addition, LHJs and school administrators may consider placing a higher priority for testing in schools that serve populations experiencing a disproportionate burden of COVID-19 cases or severe disease. These may include:

- Schools with moderate or large proportions of racial and ethnic groups that have experienced higher rates of COVID-19 cases relative to population size.
- Schools in geographic areas with limited access to testing due to distance or lack of availability of testing.
- Schools with a high proportion of multigenerational homes that include people over 60 years of age.

CDC recommends taking into consideration the level of community transmission and implementation of mitigation strategies when deciding on school-based testing. Testing in schools located in communities at moderate to highest risk may provide the maximum balance of testing efficiency.

Classrooms or schools experiencing an active outbreak may temporarily close for in-person learning. LHJs may direct or facilitate testing for students, teachers, and staff who are in schools with an active outbreak. LHJs will also conduct or direct contact tracing in these situations. Schools must assist by providing information to identify close contacts (e.g., class rosters, seating charts, and student emergency contact information). LHJs may use a tiered approach (Table 2) in an outbreak setting to determine which close contacts and other potentially exposed persons should be either isolated or quarantined and referred for or offered testing.

Once the LHJ determines the school's risk category, public health officials working in collaboration with school administrators can prioritize which staff, teachers, and students should be offered school-based testing or referred elsewhere for the same. Persons with symptoms for COVID-19 and close contacts of confirmed or probable COVID-19 patients should be considered the priority for testing. Asymptomatic staff, teachers and students who are not close contacts may also be considered for testing in schools where the risk of transmission is moderate to high. Table 2 shows how to prioritize testing for close contacts using a tiered approach. Schools should work collaboratively with LHJs to plan and conduct testing among selected groups based on the suggested hierarchy. While a collaborative approach between the LHJ and school is the preferred pathway for managing such situations, in the absence of agreement between the two, the local health officer's direction (if so expressed) is binding.

Individuals showing symptoms of COVID-19 in schools should be prioritized for testing. People with COVID-19 can report a wide range of symptoms ranging from mild symptoms to severe illness. Symptoms may appear 2 to 14 days after exposure to the virus that causes COVID-19. According to CDC guidance, symptoms may include:

- fever or chills
- cough
- shortness of breath or difficulty breathing
- muscle or body aches
- headache
- new loss of taste or smell
- sore throat
- fatigue
- congestion or runny nose
- nausea or vomiting or diarrhea

Hierarchy of testing for SARS-CoV-2 testing

Hierarchy for selection of persons for testing in schools can be as follows

1. Persons with symptoms of COVID-19.
2. Persons who have had contact with someone with COVID-19 (see Table 2 for defining and identifying contacts).

3. All students, faculty, and staff with possible exposure in the context of outbreak settings (as described in Table 2).

Table 2: Tiered approach and criteria for determination of contacts for testing

Tier 1 Close contacts Highest risk of transmission*	Students, teachers, and staff who were within 6 feet apart from the individual with COVID-19 for a total of 15 minutes or more beginning 2 days before the individual with COVID-19 became symptomatic (or, for asymptomatic individuals, 2 days prior to specimen collection) until the time of isolation.** Schools should consider the following example settings in determining close contacts: • Classrooms • Lunchrooms • Athletic teams and other extracurricular activities • After-school care and other events
Tier 2 Potential contacts Next highest risk of transmission	Students, teachers, and staff in the same classroom/cohort/pod as the person with COVID-19 who always kept 6 feet distance between persons. For example, this includes individuals in the following scenarios: • Students, teachers, or staff in the same hallway, but not sharing a classroom or bathroom. • Students who took the same bus but were farther than 6 feet apart from other riders at the same time as a person with COVID-19.
Tier 3 Potentially exposed individuals Lowest risk of transmission	Students, teachers, and staff who shared a common space (e.g., teacher's lounge, library) and were not using the space at the same time as the person with COVID-19, but where short duration exposure to those with confirmed COVID-19 cannot be definitively ruled out. For example, this includes: • Students, teachers, and staff who are in-person at the school on a different schedule and in different rooms than the individual with confirmed COVID-19, but exposure cannot be definitively ruled out.

It is important to know that the "15 minutes within 6 feet" definition is simply a tool for evaluating who might be at higher risk for contracting COVID-19. It is not a rigid rule for determining who can or cannot get COVID-19.

You could be at risk for getting COVID-19 if you have had any contact with a COVID-19 case, even if you don't meet the definition of a "close contact." That is why it is so critical to make COVID-19 prevention steps, including physical distancing and wearing a face covering, part of your everyday routine. If you think you have been exposed to a COVID-19 case, avoid close contact with others and seek testing (testing is ideally done 5-8 days after exposure).

Risk factors include:

- **How close together people are** (close interactions increase risk).
- **Length of interactions** (longer or more frequent interactions increase risk).
- **Use of face coverings** (risk is greater when people are not wearing masks).
- **Physical space** (indoor spaces with poor ventilation increase risk).
- **A case is more likely to spread COVID-19 if they have symptoms**, such as a cough. However, people can spread COVID-19 before they develop symptoms and even people who never develop symptoms can spread COVID-19.

When is testing not recommended?

If a school is implementing a testing strategy, testing should be offered on a voluntary basis. It is unethical and illegal to test someone who does not want to be tested, including students whose parents or guardians do not want them to be tested. It is not recommended to retest individuals who have previously tested positive and do not currently have symptoms for COVID-19; this recommendation continues for up to 3 months from their last positive test. Data currently suggest that some individuals test persistently positive due to residual virus material but are highly unlikely to be infectious. Parents or guardians of students claiming a recent prior positive test may be asked to pursue documentation from their health care provider to indicate the date, type, and result of the student's most recent COVID-19 test. The same may be asked of staff claiming a recent prior positive test.

Considerations before starting ANY testing strategy

Before implementing testing in their schools, K-12 administrators must coordinate with the LHJ to assess the degree of support for this approach from parents/guardians, teachers, and staff and must put key logistical elements in place:

- CLIA certificate of waiver requirements to perform school-based testing.
- Dedicated infrastructure and resources to support school-based testing including testing coordinator, clinical AND clerical support, funding, and staff training.
- Mechanism to fulfill the requirement for reporting all testing results (both positive and negative) to the LHJ or DOH.
- Plans for ensuring access to additional molecular testing when needed through a health care provider, the LHJ, or the LHJ's designated testing entity. Such additional testing may be recommended or required if a false negative or false positive initial result is suspected by the LHJ or other entity overseeing testing.
- Ways to obtain written parental consent for minor students and assent/consent for the students themselves.
- Physical space to conduct testing safely and privately.
- Ability to maintain confidentiality of results and protect student privacy.
- If these conditions are not in place, schools must move to a referral-based testing strategy in collaboration with public health officials. Districts should first consider using referral-based testing strategies, or partnerships with LHJ or local health care systems before initiating a testing program independently. There is value in establishing partnerships with healthcare providers, healthcare systems, LHJ's and private companies to conduct a testing program.

Outbreak Response Recommendations

Schools can play an important role in identifying close contacts and communicating with parents and guardians. When a school learns of a confirmed case of COVID-19 on the school premises, they should:

- Immediately notify the LHJ of the case.
- Identify and provide school-based close contacts of the case to the LHJ. This includes contacts around the case from 2 days before symptoms started (or date of positive test

if asymptomatic) until the time the case was no longer in school. Close contacts are generally defined as persons who were within six feet of the confirmed case for at least 15 cumulative minutes over 24 hours and would include siblings at the same school, those in the same cohort, and those sitting close to the student on the bus. LHJs also may define other individuals as contacts on a situation-by-situation basis when circumstances so indicate in the judgment of the health officer or his/her designee.

- LHJs will provide COVID-19 education and disease control direction to all close contacts or may delegate that task to a non-LHJ entity (e.g., school). In either case, the school should communicate directly with cases' school-affiliated close contacts and advise them to self-monitor and quarantine for 14 days from the last exposure.

Public Health Actions

A COVID-19 outbreak is considered when the following have been met:

- There are two or more laboratory-positive (PCR or antigen) COVID-19 cases among students or staff.
- The cases have a symptom onset within a 14-day period of each other.
- The cases are epidemiologically linked or related to each other defined as knowing the person, or being at the same place or at the same time.
- The cases do not share a household.
- The cases are not identified as close contacts of each other in another setting during the investigation

When to close a classroom

If the school is grouping or cohorting students, dismiss the entire classroom for home quarantine for 14 days if two or more laboratory positive (PCR or antigen) COVID-19 cases occur within the group or cohort within a 14-day period.

When to close a school to in-person learning and switch to remote learning for 14 days:

- 2 or more classrooms are dismissed due to outbreaks in schools with 10 or fewer classrooms.
- At least 2 classrooms or greater than 10% of classrooms are dismissed due to outbreaks in schools with greater than 10 classrooms.
- School cannot function due to insufficient teaching or support staff.

When to close the school to in-person learning if not grouping or cohorting students:

Quarantine close contacts and notify families if two or more laboratory positive (PCR or antigen) COVID-19 cases are reported in a 14 day period. In consultation with the LHJ, evaluate to determine if transmission is occurring in the school.

Consider the following to determine the need to close a school and switch to remote learning for 14 days when:

- The school experiences a rapid increase in cases.
- There is a prolonged chain of transmission (2 or more generations) occurring in the school.
- School cannot function due to insufficient teaching or support staff.

Employer Health and Safety Requirements for Schools

- The overall health risk for the typical K–12 in-person instructional setting is classified as low risk. There are other scenarios in the school setting where the risk level may be higher or lower.
- In low risk situations, staff may wear a cloth face covering.
- In medium risk situations, L&I's long-standing guidance allows for several different protection options, including a face shield with a cloth face mask (K-12 only), a surgical-style mask, a hobby dust mask, a KN95 mask, or a KN90 mask.
- For high risk or extremely high-risk situations, an N95 respirator or equivalent must be used. If an employer cannot reasonably obtain an N95 or equivalent, they may use a face shield plus an FDA approved surgical mask, procedural mask, or a KN95 mask until a respirator can be obtained. This will be the case when an outbreak investigation is occurring. The LHJ will advise each school on the best PPE for that situation and employee involved.
- N95 respirators or equivalent protection are required in high risk or extremely high-risk situation. For staff working in such settings, establishment of a respiratory protection program to include fit testing of staff is/is not required prior to implementation of such respiratory protection.

More COVID-19 Information and Resources

Stay up-to-date on the current COVID-19 situation in Washington, Governor Inslee's proclamations, symptoms, how it spreads, and how and when people should get tested. See our Frequently Asked Questions for more information.

A person's race/ethnicity or nationality does not, itself, put them at greater risk of COVID-19. However, data are revealing that communities of color are being disproportionately impacted by COVID-19- this is due to the effects of racism, and in particular, structural racism, that leaves some groups with fewer opportunities to protect themselves and their communities. Stigma will not help to fight the illness. Share accurate information with others to keep rumors and misinformation from spreading.

- WA State Department of Health 2019 Novel Coronavirus Outbreak (COVID-19)
- WA State Coronavirus Response (COVID-19)
- Find Your Local Health Department or District
- CDC Coronavirus (COVID-19)
- Stigma Reduction Resources

Have more questions about COVID-19? Call our hotline: **1-800-525-0127,** Monday – Friday, 6 a.m. to 10 p.m., Weekends: 8 a.m. to 6 p.m. For interpretative services, **press #** when they answer and **say your language.** For questions about your own health, COVID-19 testing, or testing results, please contact a health care provider.

To request this document in another format, call 1-800-525-0127. Deaf or hard of hearing customers, please call 711 (Washington Relay) or email civil.rights@doh.wa.gov.